FORM APPROVED

California Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA930000058	A. BUILDING _____ B. WING _____	11/01/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARFIELD MEDICAL CENTER	525 N GARFIELD AVE MONTEREY PARK, CA 91754

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 000	Initial Comments The following reflects the findings of the Department of Health Services during a Complaint Investigation. Intake No. CA00064612 Representing the Department of Health Services: Dolores Braithwaite, R.N., HFE	E 000		
E 264	T22 DIV5 CH1 ART3-70213(a) Nursing Service Policies and Procedures. (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. This RULE: is not met as evidenced by: Based on medical record review, administrative document review, and staff interview, the facility failed to maintain and implement policy # PA-02, entitled "Assessment of Pediatric Patient" for Patient A. Findings include: On November 2, 2005, at 6:30 a.m., an interview with the triage nurse (RN1), who provided care for Patient A on October 10, 2005, disclosed that when Patient A was initially assessed for pain, she was asleep and not in any apparent pain. When Patient A had her sweater removed so that RN1 could evaluate an injury to her arm, RN1 stated the patient "cried out in pain". However, RN1 stated her initial assessment should have been changed to reflect Patient A's pain. RN1 failed to accurately assess Patient A for the 5th Vital Sign (Pain) as stipulated in Policy # PA-02 "Assessment of	E 264		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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E 264	Continued From Page 1 Pediatric Patient". Additionally, upon medical record review, another nurse RN2, failed to implement the same facility policy regarding an assessment/reassessment of Patient A's pain level.	E 264		
E 269	T22 DIV5 CH1 ART3-70213(b) Nursing Service Policies and Procedures. (b) Policies and procedures shall be based on current standards of nursing practice and shall be consistent with the nursing process which includes: assessment, nursing diagnosis, planning, intervention, evaluation, and, as circumstances require, patient advocacy. This RULE: is not met as evidenced by: Based on medical record review, staff interview and administrative document review, the facility failed to assess, intervene, and as circumstances required, provide advocacy for Patient A. Findings include: An interview with RN1 on November 2, 2005, at 6:35 a.m., disclosed that during the time she had been providing care to Patient A, "the child was staring at me in a way that had bothered me a lot" yet, she "did nothing about it". RN1 stated during the interview that she "did not get the story" about how Patient A fell from the woman who had identified herself as Patient A's "mother". Although the "mother" had told her the patient's arm was dislocated, she stated it was obvious to her the arm was broken. However, she did not question the "mother " any further.	E 269		

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E 269	Continued From Page 2 During an interview on November 2, 2005, at 12:15 p.m., RN2, the primary caregiver for Patient A, on October 10, 2005, stated that she had assessed the patient as having "no pain". In addition, RN2 stated the following during the interview conducted with the Evaluator: 1. The patient "didn't respond like a normal child" to the injury and withdraw from the pain when examined by her. 2. The injury was unexplained. The woman who had identified herself as Patient A's "mother" had told her, she "didn't know how or when the injury occurred", adding that when she "noticed that her child was injured she came to the hospital for care". 3. Patient A had signs of dehydration and was given intravenous fluids (IV), Normal Saline, to treat those symptoms. The medical record indicated that 300 cc (cubic centimeters) of IV fluids were given. 4. Patient A was "just staring and not responding to pain appropriately", RN2 further stated that she had interpreted the stare as Patient A being "mentally retarded"; even though when she had questioned the "mother" regarding the patients possible retardation, the "mother" denied that assertion. RN2 failed to recognize the above observed indicators of suspected child abuse as defined in the facility's policy # PA-03, Emergency Room-Pediatrics titled: Child Abuse. Based on RN1 and RN2's failure to implement the facility's policy PA-03, as outlined, (i.e. recognition of indicators of suspected child abuse), resulted in a missed opportunity to advocate for Patient A (lack of complete assessment and intervention).	E 269		

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E 731	Continued From Page 3	E 731		
E 731	T22 DIV5 CH1 ART6-70415(a)(1) Basic Emergency Medical Service, Physician on (1) Implementation of established policies and procedures. This RULE: is not met as evidenced by: Based on medical record review, staff interview, and administrative document review, MD1, as a member of the medical staff, failed to follow facility policy/procedures (PA-03 Emergency Room-Pediatrics, policy title: Child Abuse) and consequently violated the Medical Staff Bylaws. Findings include: Medical record review revealed that MD1 ordered a CT scan of Patient A's head and documented that the CT scan was to "rule out a bleed in the head". MD1 also documented on the Leaving Hospital Against Medical Advice (AMA) form that "Child (Patient A) may have other injuries or lose her limb or life." The woman who identified herself as Patient A's "mother", refused the CT scan and left AMA before a CT scan could be performed on Patient A. An interview on November 2, 2005, at 6:35 a.m., with RN2, disclosed that she and MD1 wanted to make sure "there wasn't anything wrong like a tumor" with the patient's head as Patient A had appeared to "be mentally retarded or at the very least developmentally slow" and not responding appropriately for the injury sustained. Furthermore, the medical record also documented that Patient A's "mother", had refused other diagnostic studies as well, (i.e. blood lab work-up and an urine analysis).	E 731		

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E 731	Continued From Page 4 MD1 failed to to observe the indicators of suspected child abuse, i.e. refusal by the "mother" for further diagnostic studies and decisions made by the "mother" that were not consistent with the child's best interest, as in the facility's policy # PA-03, Emergency Room-Pediatrics, policy title: Child Abuse.	E 731		
E2229	T22 DIV5 CH1 ART7-70751(a) Medical Record Availability (a) Records shall be kept on all patients admitted or accepted for treatment. All required patient health records, either as originals or accurate reproductions of the contents of such originals, shall be maintained in such form as to be legible and readily available upon the request of: This RULE: is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain a legible medical record for Patient A. Findings include: A medical record review for Patient A's emergency room visit on October 10, 2005, had multiple illegible entries. On the facility's "E.D. Physician Chart", the handwritten history of present illness was not legible. The entries on this form were handwritten by the attending Emergency Room (ER) physician (MD1) and were mostly illegible. The "ER Course & Procedures" portion of the form, although it was completed was totally illegible. That portion of the form that MD1 placed his/her signature was illegible as was the area MD1 filled in with his/her	E2229		

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E2229	Continued From Page 5 printed name. An interview with the Director of Emergency Services on November 1, 2005, disclosed that she too could not decipher all of MD1's entries in Patient A's medical record.	E2229		